

Health and Nutrition Screening Form

Breastfeeding/Postpartum Women

Name: _____

Date: _____

Just by enrolling today you show that you really care about yourself. We want the same things for you. We are here to help you become healthy and strong.

To do this, we need to ask some questions about the food you eat, your health, how much you exercise, and how you feel about things in general. The answers to these questions will be kept confidential so please answer carefully and honestly.

Please check (✓) the answer or fill in the blank.

1. Please describe your appetite:	<input type="checkbox"/> Good: I enjoy food and I like to eat.
	<input type="checkbox"/> Fair: Food is okay; but I have trouble eating sometimes.
	<input type="checkbox"/> Poor: I don't enjoy eating very much. I find it hard to eat.
2. Has your appetite changed in the past six weeks?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, how?	
Are you satisfied with your eating patterns?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Has your doctor recommended any diet changes?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, what?	
4. How many times a day do you eat?	<input type="checkbox"/> 1 or 2 <input type="checkbox"/> 3 or 4 <input type="checkbox"/> 5 or 6
(Include meals and snacks)	
How many meals do you eat away from home?	<input type="checkbox"/> per day <input type="checkbox"/> per week
5. Do you have any food allergies?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, which foods?	
6. What do you do for exercise?	<input type="checkbox"/> walk <input type="checkbox"/> bike <input type="checkbox"/> dance <input type="checkbox"/> swim <input type="checkbox"/> aerobics
How often do you exercise now?	
7. Have you had a dental visit for a cleaning in the past 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you now have 1 or more teeth that need to be filled or pulled?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Which of the following statements best describes the food eaten in your household during the last month?	
	<input type="checkbox"/> Enough and the kind wanted to eat
	<input type="checkbox"/> Enough but not always the kind wanted to eat
	<input type="checkbox"/> Sometimes not enough
	<input type="checkbox"/> Often not enough to eat

Foods You Ate In The Past 4 Weeks:

Please write in the number of times in a day, week or month that you ate the following foods.

For example, during the past month if you ate:

Cereal once a day, write a 1 in the Daily column after cereal.

Salad 4 times a week, write a 4 in the Weekly column.

Sweet potatoes twice a month, write a 2 in the Monthly column.

If you don't eat the food listed, place a check (✓) in the Never column.

	Daily	Weekly	Monthly	Never
Cereal: Hot or cold	1			
Lettuce, green or red leaf, romaine		4		
Carrots, sweet potatoes, winter squash			2	
Port, roast or chops, ham				✓

Bread and Cereal

	Daily	Weekly	Monthly	Never	
Whole grain (wheat or oat) bread, rolls, or bagels (indicate the number of slices eaten per day or week)					
White bread, rolls, bagels or buns (indicate the number of slices eaten per day or week)					
Muffins, waffles, pancakes, quick breads, biscuits					
Cereal: Hot or Cold					
Pasta (spaghetti, macaroni, noodles)					
Rice, barley, bulgur					(84)
Crackers, pretzels, popcorn					Std. 42
	$\times 7 =$		$\div 4 =$		

Fruit and Fruit Juice

	Daily	Weekly	Monthly	Never	
100% juice with Vitamin C added (WIC juice), orange or grapefruit juice. How many ounces do you drink at a time? _____					
Oranges, grapefruit, strawberries					
Cantaloupe, watermelon					
Apples, bananas, grapes, pears, applesauce, canned fruit					(86)
Raisins, dried apricots, prunes					Std. 14
	$\times 7 =$		$\div 4 =$		

Vegetables	Daily	Weekly	Monthly	Never	
Carrots, sweet potatoes, winter squash					
Broccoli, spinach, beet greens, swiss chard					
Tomatoes, tomato sauce, red or green peppers, cabbage					
Potatoes, baked, boiled, roasted or salad					
Corn, peas, green beans, beets					
Lettuce, green or red leaf, romaine					(83)
Soup: Vegetable or Tomato					Std. 21
	x 7 =		÷ 4 =		

Meat, Poultry, Fish and Beans	Daily	Weekly	Monthly	Never	
Peanut Butter, nuts					
Baked beans, pinto or kidney beans, chili or refried, hummus					
Hamburger (prepared in any way)					
Chicken or turkey					
Hot dogs, cold cuts, sausage or bacon					
Tofu, Tempeh					
Fish or Fish sandwich, Fish sticks, Canned tuna					
Steak or roast (beef, venison)					
Pork, roast or chops, ham					(82)
Eggs					Std. 14
	x 7 =		÷ 4 =		

Milk and Cheese	Daily	Weekly	Monthly	Never	
Which type of milk? (circle) Skim, 1%, 2%, whole How many ounces do you drink at a time? _____					(81)
Yogurt					PP > 25 Std. 21
Ice Cream, pudding or cottage cheese					PP < 25 Std. 28
Hard cheese: American, Cheddar					BF > 25 Std. 28
Meals with Cheese: Pizza, Macaroni and Cheese					BF < 25 Std. 35
	x 7 =		÷ 4 =		

Other	Daily	Weekly	Monthly	Never	
Cookies, cake, brownies, pie, candy bars					
Chips (potato, corn, other), french fries					
Soda, Kool-aid, Hi-C, Tang					
Coffee/ Tea					
Water					

Health and Nutrition Screening Form Breastfeeding/Postpartum Women

Please check (✓) the answer or fill in the blank.

9. Do you take vitamin and/or mineral supplements? ____Yes ____No

If yes, what kind?

10. Are you taking any drugs or medications now? ____Yes ____No

What kind?

How often?

Prescription: _____

Non-prescription (over the counter): _____

Home remedies: _____

Are you taking other drugs such as crack, cocaine, heroin, acid, marijuana, or inhalants (glue/paint) ?

____Yes ____No

11. A drink is 1 can or bottle of beer, 1 glass of wine, 1 can or bottle of wine cooler, or 1 mixed drink or 1 shot of liquor.

In the last three months of your pregnancy, on the average,
how many days per week or per month did you drink any alcoholic beverages?

____Days per week ____ Days per month ____Don't know/not sure ____Did not drink

On days when you drank, about ***how many drinks did you drink*** on the average?

____ 1-2 ____3-4 ____5-6 ____7-8 ____9-10 ____Don't know/ not sure ____Did not drink

12. ***During the past month,*** on the average,
how many days per week or per month did you drink any alcoholic beverages?

____Days per week ____ Days per month ____ Don't know/not sure ____Did not drink

On days when you drank, about ***how many drinks did you drink*** on the average?

____ 1-2 ____3-4 ____5-6 ____7-8 ____9-10 ____Don't know/ not sure ____Did not drink

13. Have you ever had a problem with drinking? ____Yes ____No

14. Have friends or family suggested you have a problem? ____Yes ____No

Date Assessed: _____